Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: DOWNTOWN PERFORMANCE MEDICAL CENTER 3033 FANNIN ST. HOUSTON, TX 77004	MFDR Tracking #: M4-10-3828-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: ARCH INSURANCE CO Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting your assistance in processing the medical bills related to the above-mentioned patient for DOS 05/28/2009. Payments were denied for the following reason: 19 – Payment denied due to lack of pre-authorization. This charge in this bill we {sic} erroneously entered. The DME provided for the patient was a rental; therefore, the charge on this DME is below $500.00. All DME's billed under $500.00 do not require pre-authorization. The following documents are included in this packet: Original bills, medical records, request for reconsideration."

Amount in Dispute: $180.00

PART III: RESPONDENT'S POSITION SUMMARY

The Respondent did not respond to this dispute.

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
5/28/09	E0745-RR	N/A	$180.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for the professional services rendered on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 7/30/2009

   - BL – This bill is a reconsideration of a previously reviewed bill.
   - 15 – (15) The authorization number is missing, invalid, or does not apply to the billed services or provider.
   - 15 – (15) This line was included in the reconsideration of this previously reviewed bill.

Issues

1. Did the requestor submit the medical bill for the services in dispute in accordance with 28 Tex. Admin. Code §133.307?
2. Does the submitted documentation support the services billed under HCPCS code E0745-RR?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor submitted two bills with HCPCS code E0745-RR and one reconsideration EOB. The requestor's position statement states that "This charge in this bill we {sic} erroneously entered. The DME provided for the patient was a rental; therefore, the charge on this DME is below $500.00." Both of the bills submitted in the dispute are billed with HCPCS code E0745-RR. In regard to this, there is no other bill submitted to support the requestor's position statement. Pursuant to rule §133.307(c)(2)(A)(B) Provider requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. The request shall include: a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as **originally** submitted to the carrier and a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute. Without the original billing and the original EOB denial, the Division is unable to determine what was originally billed that would support the Carrier's denial of the service requiring pre-authorization. Therefore, the requestor did not submit this dispute in accordance with rule §133.307.
2. The description of HCPCS code E0745-RR is as follows: Neuromuscular stimulator, electronic shock unit-rental. The documentation the requestor submitted to support the charge is a "item delivered" document signed and dated by the injured worker. It supports the items delivered as: 1. Hot ice system three, 2. Thermophore moist heat pad, 3. EMS, 4. Hinged knee brace, 5. Soft good(s) and 6. Other item(s) with an unidentifiable handwritten note. There is no other documentation submitted in this dispute to support the charges. None of these items marked meet the description of HCPCS code E0745-RR. Furthermore, the Medicare DME MAC Jurisdiction C Supplier Manual states that "Detailed written orders are required for all transactions involving DMEPOS. All orders must clearly specify the start date of the order. The written order must be sufficiently detailed and the description can be either a narrative description or a brand name/model number. If the order is for a rented item, the order must include the length of need." Pursuant to §134.203(a)(5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare. The Division submitted a request to the requestor for the original medical bill and the original EOB on 12/7/2010 however, the requestor did not respond. The requestor did not submit the bill in accordance with rule §134.203 and therefore payment is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

		12/29/10
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.